1512 Santa Fe Dr, Ste 103
Weatherford, TX 76086
817-594-3434

Roberts chiropractic

Today's Date_____

Referred By_____

Legal First Name_____ Nick Name_____

Last Name_____ DOB_____

Address_____ APT_____

City_____ State_____ Zip Code_____ Gender M ☐ F ☐

Marital Status_____ Spouse Name_____

SSN_____ Email_____

Phone Number_____ Cell Phone Number_____

Appointment Reminders will be emailed or texted to you. Normal fees apply. Initial_____

Cell Provider_____

Occupation_____ Employer_____

Employer Address_____

City_____ State_____Zip Code_____ Phone Number_____

Please check the following

☐ Self-Pay

☐ Insurance: Policy Holder: Patient ☐ Spouse/Parent ☐

☐ Personal Injury

"I verify the accuracy of the above information and I authorize the release of any medical information necessary to process any claims. I request payment of this claim and, if the payer accepts assignment, I authorize payment directly to the physician or supplier for the services described."

Patient or Authorized Signature_____ Date_____

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Name _____ Date_____

Assignment and Release

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all serviced rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

Patient or Authorized Signature _____ DATE _____

INFORMED CONSENT

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process. This "pop" is gas released from the joint as the joints are moved. Additionally, following the adjustment, some patient's experience soreness and tenderness for a few minutes to days, depending on the severity of their condition.

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

Additionally, there will be procedures and therapies that may be performed on me during the course of my care. These are, but not limited to spinal decompression, electric stimulation, cold laser, myofacial work, ultrasound, massage, physical exercises and strengthening. All of these procedures are and can be used to assist with your care. Each of these therapies have their own associated risks including, shocks or burns, frost bite, bruising, sore muscle, injury or strain to a disc and or surrounding structures (decompression) and damage to my eyes (cold laser).

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

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Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date_____ Attempt_____

Staff Name_____

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WHAT TO EXPECT AFTER YOUR FIRST ADJUSTMENT

Please read the following information carefully. Sign the bottom of the sheet to indicate that you understand the instructions and information given.

1. If you have never been adjusted, or if it has been awhile since your last adjustment, you may experience soreness or discomfort for a few hours to a few days. This is a normal reaction to chiropractic adjustments.

2. If you are sore, use ice packs on the affected area. Ice therapy consists of the use of ice packs at 20-minute intervals followed by 40 minutes of rest. This can be repeated as often as needed. Do not apply ice directly to bare skin. Always protect skin with a thin covering such as a shirt or light towel. Cover the ice pack with a thick towel to retain the cold.

3. Do not use heat except under the doctor's instruction. Heat may aggravate your injury.

4. Stay away from heavy lifting or repetitive movements until the doctor indicates you are ready for normal activities. Strenuous athletic activities such as running, lifting weights, impact aerobics, racquetball, tennis, skiing, bowling, etc. should be avoided. Other things to avoid are yard work such as raking, digging, lifting heavy objects such as groceries, pets and children, and any other activities that could aggravate or re-injure your condition.

5. Unless indicated by the doctor, you may return to work/school after your appointment.

6. If a sudden movement causes sharp or severe pain, or if you experience swelling, contact the clinic at 817-594-3434. After hours, contact Dr. Roberts at 972-977-6365.

I have read and understand the instructions given for my follow-up care.

_____ _____

Patient's Signature Date

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PATIENT/DOCTOR AGREEMENTS

The purpose of this agreement is to allow us to more completely serve you and for you to get the best results in the shortest amount of time. It is in our experience that those patients who follow through with these agreements get the best results.

CELL PHONES

Cell phones must be TURNED OFF or ON VIBRATE while in the office as not to disrupt other patients. _____Initial

APPOINTMENT TIMES

A $35 charge will be given if you do not call to cancel an appointment 24 hours in advanced. _____Initial

SIGNING IN

When you arrive, please sign in. The Doctor will be with you as soon as possible.

MISSING OR CHANGING APPOINTMENTS

The Doctor has set up a specific course of treatment for you to get the results we both desire. If you need to reschedule your appointment, it is important that you make up the missed appointment within one week.

PAYMENT OF BILLS

We will expect you to honor the financial agreement you make with our office. In order to serve you better, please plan to make payments at the front desk after your adjustment/treatment. If you have suspended or terminated your care without your Doctor's approval, payment for service is due immediately.

PROGRESS EVALUATIONS AND RE-EXAMINATIONS

During your treatment series, re-examinations and progress reports will be done on a regular basis.

COMMUNICATION

Please communicate directly to your Doctor any upsetting matter such as waiting too long, rudeness by any staff member, failure to understand treatment, need for extended consultation, etc. Your input is important will help us to help you, as well as others.

CASH PATIENT FINANCIAL POLICY

We request that 100% of the first visit be paid at the time of the first visit. For your convenience, future payments may be arranged at the first visit of each week. We are happy to accept cash, check, MasterCard, Visa, American Express, or Care Credit.

AUTO ACCIDENT/PERSONAL INJURY

Your eligibility depends on your specific case. You are responsible for obtaining an insurance form or address to which we send statements for you care. You are also responsible for reporting your accident to the insurance company and your agent.

AUDIO/VIDEO RECORDING IN OFFICE

To ensure confidentiality and privacy, any type of electronic recording or videoing is strictly prohibited at any location within these offices without written notification to the Doctor and Staff. This includes cell phones and smart devices.

I, _____understand the above policy and agree to abide by it.
(PRINT NAME)

_____ _____
(SIGNATURE) (DATE)

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TO: Dr. Roberts/Roberts Chiropractic & Staff

Patient Name: _____

REFERENCE: Photo Identification, Storage, and/or Usage

1. I hereby give permission to have my photograph stored on your patient records electronic system to assist with proper record identification

2. I hereby give permission to Dr. Roberts (Roberts Chiropractic) to use my name and/or photograph on your social media (Facebook, Instagram, etc.), patient newsletter, and on any office bulletin or other notice boards for purposes of announcing births, birthdays, weddings, graduations or acknowledging my referrals.

Patient or Authorized Signature _____ DATE _____